North Carolina Medicaid Uniform Screening Program Training Session Registration Form (No Fees)
(Please print clearly)

Provider Name____

Address____

City, Zip Code______________________________________County____________________

Name of Training Session Attendee____

Attendee's E-mail Address____

Telephone Number ( )____

Fax Number ( )____

I will attend the training session on________________at________________________
(date) (location)

Please fax completed form to:
Uniform Screening Program
EDS Provider Services
P.O. Box 300015
Raleigh, NC 27622
Fax: 919-816-3145